HAMILTON BOARD OF HEALTH

APLLICATION FOR LICENSE OF PROFESSIONAL PRACTITIONER OF MASSAGE THERAPY

Please supply the following information and documents:

NAME: _____

HOME ADDRESS: _____

_____

BUSINESS NAME: _____

BUSINESS ADDRESS(S): _____

_____

_____

_____

PHONE: _____

TRAINING

Educational: _____

_____

_____

_____

Certification of Licensure: _____

_____

_____

HAMILTON BOARD OF HEALTH
APPLICATION FOR LICENSE OF PROFESSIONAL PRACTITIONER OF MASSAGE THERAPY

References:

Name	Address	State	Zip	Phone

1. **Please submit to the Board of Health results of a physical examination including a Mantoux test within the past forty-five (45) days.**

2. **Please submit to the Board of Health two (2) forms of positive identification and a birth certificate indicating you are eighteen (18) years or older.**

3. **Documentation from training program (Please attach to application)**

4. **License certification documentation (Please attach to application)**

5. **Please submit fee of $50.00 for each professional masseuse**

6. **Please submit fee of $250.00 for establishment**

I have received, read and agree to abide by the Rules and Regulations for the Practice of Massage and the Conduct of Establishments for the giving of Massage, vapor, Pools, Shower, or Other Baths in the Town of Hamilton. I am informed of and agree to abide by the standards for practice and ethical guidelines of my professional association. I certify that I have not herein misrepresented my training, credentials or title, nor shall I misrepresent them to the public.

Professional Practitioner Signature: _____

Date: _____

To Be Filled Out By Physician

History:

List all medical problems:

_____

_____

_____

_____

List communicable diseases:

_____

_____

_____

List current medications:

_____

_____

_____

_____

Last PPD: _____ Results: _____

Blood Pressure _____ Pulse _____ Respiratory Rate _____

Weight _____

Ears _____ Nose _____ Throat _____ Neck _____ Skin_____

Lungs _____ Abdomen _____ Heart _____

Neurological _____

Overall Impression:

I certify that _____ has been recently examined and has no risk of transmitting disease, including tubercles, while employed by as a massage therapist.

Signature of Physcian _____ Date: _____